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No. 84-1038

IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

MARIO DE MODENA, dba SIXTH AVENUE PHARMACY, *et al.*,
Petitioners,

v.

KAISER FOUNDATION HEALTH PLAN, INC., *et al.*,
Respondents.

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC.,
Petitioner,

v.

KAISER FOUNDATION HEALTH PLAN, INC., *et al.*,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

MOTION OF AMERICAN PHARMACEUTICAL ASSOCIATION FOR LEAVE TO FILE BRIEF AS AMICUS CURIAE IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI AND BRIEF AMICUS CURIAE

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American Pharmaceutical Association

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Counsel for the Petitioners has consented to the filing of the attached brief. Counsel for the Respondents have not consented to its filing.

The American Pharmaceutical Association (APhA) is a nonprofit, membership corporation organized and existing under the laws of the District of Columbia since 1852. It is the national professional society of pharmacists in the United States, and its membership consists of about 38,000 practicing pharmacists, pharmaceutical scientists and educators. Additionally, about 12,000 students enrolled in colleges of pharmacy hold student membership in APhA.

APhA member pharmacists practice their profession in a variety of settings. Some are owners of community pharmacies. Other are employed pharmacists in community pharmacies and in both nonprofit and for-profit hospitals. Yet others serve in the Armed Forces and in government and private health care administration positions. A substantial number of APhA members are employed by Health Maintenance Organizations. APhA itself has no commercial interest in any pharmacy, nor does it represent the proprietary interest of pharmacist owners of community pharmacies as such.

APhA and, of course, its members are vitally interested in the public health and welfare as they may be affected by the profession of pharmacy. In that regard, APhA's contemporary purpose is to render assistance in improving, promoting, and safeguarding the public health and welfare by: (A) participating in a system of education and training for pharmacists and recommending standards of professional practice; (B) disseminating knowledge to promote the safe and effective use of drugs; (C) encouraging and maintaining relations with other health professions; (D) participating as representative of the profession of pharmacy in the processes of government; (E) encouraging interest in the practice of pharmacy as a professional career and supporting systems of educational accreditation and licensure; (F) providing and maintaining a Code of Ethics for pharmacists; (G) fostering research; and (H) pursuing such other lawful purposes within its corporate powers as may be approved from time to time by its members or Board of Trustees.

Community pharmacists today are licensed professional practitioners, and those owning pharmacies are simultaneously small business proprietors in a highly competitive market for pharmaceutical services. APhA and its members vigorously support the American free enterprise system which provides the only meaningful climate under which professionals and small businesses can survive economically, have the opportunity to succeed by their own efforts, and perform essential health care services to their communities. APhA is dedicated to the preservation of a competitive market place.

APhA and its members have a vital interest in assuring the continued widespread availability of pharmaceutical service to the public when and where such service is required. For many persons, the pharmacist is the most readily-accessible health care professional and, in addition to providing generally-recognized drug information and dispensing services, the pharmacist often serves as an initial point of contact or entry for those persons not having a regular relationship with the health care system or its professional practitioners.

APhA recognizes that the realities of pharmacy practice, as that practice has developed uniquely in this country, include various means and agencies through which pharmaceutical service is provided to the public under different social, economic and health care requirements. The only issue in the instant case, however, involves the providing of pharmaceutical service by asserted nonprofit and "charitable" Health Maintenance Organizations to individuals for whose patronage other providers of pharmaceutical service compete. Under the Ninth Circuit opinion, such Health Maintenance Organizations enjoy an overwhelming anti-competitive advantage.

Your amicus is dedicated to preserving consumer choice of pharmaceutical service to meet public health needs. APhA recognizes, however, that this objective will fail if any segment of competing pharmaceutical service providers is economically disadvantaged so as to be eliminated or threatened with elimination.

WHEREFORE, the American Pharmaceutical Association requests this Court to grant this motion and permit the Association to file the brief amicus curiae attached hereto.

Respectfully submitted,

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BRIEF OF AMERICAN PHARMACEUTICAL ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI

PRELIMINARY STATEMENT

The American Pharmaceutical Association (APhA) submits this brief amicus curiae in support of the Petitioners, Mario DeModena, dba Sixth Avenue Pharmacy, et al., and Portland Retail Druggists Association, Inc.

INTEREST OF AMICUS

The American Pharmaceutical Association (APhA) is a nonprofit, membership corporation organized and existing under the laws of the District of Columbia since 1852. It is the

national professional society of pharmacists in the United States, and its membership consists of about 38,000 practicing pharmacists, pharmaceutical scientists and educators. Additionally, about 12,000 students enrolled in colleges of pharmacy hold student membership in APhA.

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APhA and, of course, its members are vitally interested in the public health and welfare as they may be affected by the profession of pharmacy. In that regard, APhA's contemporary purpose is to render assistance in improving, promoting, and safeguarding the public health and welfare by: (A) participating in a system of education and training for pharmacists and recommending standards of professional practice; (B) disseminating knowledge to promote the safe and effective use of drugs; (C) encouraging and maintaining relations with other health professions; (D) participating as representative of the profession of pharmacy in the processes of government; (E) encouraging interest in the practice of pharmacy as a professional career and supporting systems of educational accreditation and licensure; (F) providing and maintaining a Code of Ethics for pharmacists; (G) fostering research; and (H) pursuing such other lawful purposes within its corporate powers as may be approved from time to time by its members or Board of Trustees.

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businesses can survive, economically have the opportunity to succeed by their own efforts, and perform essential services to their communities. APhA is dedicated to the preservation of a competitive market place.

APhA and its members have a vital interest in assuring the continued widespread availability of pharmaceutical service to the public when and where such service is required. For many persons, the pharmacist is the most readily-accessible health care professional and, in addition to providing generally-recognized drug information and dispensing services, the pharmacist often serves as an initial point of contact or entry for those persons not having a regular relationship with the health care system or its professional practitioners.

APhA recognizes that the realities of pharmacy practice, as that practice has developed uniquely in this country, include various means and agencies through which pharmaceutical service is provided to the public under different social, economic and health care requirements. The only issue in the instant case, however, involves the providing of pharmaceutical service by asserted nonprofit and "charitable" Health Maintenance Organizations to individuals for whose patronage other providers of pharmaceutical service compete. Under the Ninth Circuit opinion, health maintenance organizations enjoy an overwhelming anti-competitive advantage.

Your amicus is dedicated to preserving consumer choice of pharmaceutical service to meet public health needs. APhA recognizes, however, that this objective will fail if any segment of competing pharmaceutical service providers is economically disadvantaged so as to be eliminated or threatened with elimination.

ARGUMENT

THE NINTH CIRCUIT ERRED IN HOLDING THAT RESPONDENT HMO'S ARE "CHARITABLE INSTITUTIONS" UNDER THE NONPROFIT INSTITUTIONS ACT EXEMPTION TO THE ROBINSON-PATMAN ACT

The holding of the court below that the Health Maintenance Organizations involved in this litigation are eligible for exemption as "charitable institutions" is contrary to obvious fact, and has no foundation in law. In addition, the superficial analysis of this critical issue found in the Ninth Circuit's opinion is utterly contrary to prior decisions of this Court construing the Robinson-Patman Act and the limited Nonprofit Institutions Act exemption.

The Ninth Circuit's opinion wrongly departs from well established antitrust policy and analysis. In reaching the unfounded conclusion that respondent HMOs are "charitable institutions" the court below wholly ignored the massive market power of the Kaiser-Permanente Medical Care conglomerate and its highly commercialized marketing orientation. The Kaiser-Permanente Medical Care Program Annual Report for 1983 (inside cover) describes the organization in the following terms:

> The Program is a joint endeavor involving representatives of the professions of medicine and management, sharing responsibilities for organizing, financing and delivering quality health care services on a prepaid basis. Medicine is represented by separate and independent Permanente Medical Groups, and Management by Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals. The Program serves more than 4,400,000 voluntarily enrolled members in California, Colorado, Hawaii, Ohio, Oregon, Washington, Texas, the metropolitan Washington, D.C. area and Connecticut.

The Kaiser Foundation Health Plan Financial Statement for 1982 and 1983 which is reproduced in its entirety in the

Appendix at 1a reflects that in 1983 the organization had total revenues in excess of $2.9 billion. Expenditures for 1983 reflect that $2.7 billion was spent for medical services, while approximately $73 million was spent for "Health Plan Administration." App. at 2a. The corporation reported a net worth in 1983 in excess of $611 million. App. at 12a. These are extremely impressive figures for a alleged non-profit "charitable institution." Kaiser-Permanente is by far the largest Health Maintenance Organization in the country with over seven times the enrollment of its nearest competitor. App. at 2b. A recent interview with a Kaiser Vice President indicated that the conglomerate has every intention of expanding its market penetration in the years to come.

> In a race to establish national networks, Kaiser Foundation Health Plan, Inc. the largest HMO, is spending $300 million on expansion this year, [1984] according to Robert J. Erickson, senior vice president. He said *Kaiser plans to spend $2 billion in the next five years.* From its California base, Kaiser has jumped to nine other states and the District of Columbia. It added 200,000 members this year, for a total of 4.6 million. Revenues passed $3 billion.
>
> In 1985, Kaiser will add three more states, including New York, where it plans to expand the Westchester Community Health Plan, a small HMO in White Plains (emphasis added).

New York Times. Dec. 17, 1984 (App. at 3b)

Your amicus respectfully submits that the respondents, which look and act like a "Fortune 500" conglomerate, cannot be treated as "charitable institutions" for purposes of the application of the antitrust laws. The immense market power and capability for expanding that market power evidenced by the foregoing report constitutes a serious threat to competition to providers of pharmaceutical service. If the Ninth Circuit's view prevails, expansive HMOs possessing financial strength far in excess of the resources of independent community pharmacies, or even drug store chains will enjoy an exemption from the discriminatory pricing protections of the antitrust laws.

Such a result would defeat the fundamental purpose of the Robinson-Patman Act and circumvent the limited purpose of the Nonprofit Institutions Act as earlier construed by this Court. That purpose is to provide financial relief to struggling eleemosynary institutions.

On numerous occasions, this Court has affirmed the comprehensive coverage of the antitrust laws and has recognized that those laws represent "a carefuliy studied attempt to bring within the [antitrust laws] every person engaged in business whose activities might restrain or monopolize commercial intercourse among the states." *United States v. South-Eastern Underwriters Ass'n.*, 322 U.S. 533, 553 (1944). This court has also strictly construed any asserted exclusions from those laws. In *Jefferson City Pharmaceutical Ass'n v. Abbott Laboratories*, 460 U.S. 150 (1983) this Court held that:

> It has been said, of course, that the antitrust laws, and Robinson-Patman in particular, are to be construed liberally, and that the exceptions from their application are to be construed strictly. (citations omitted). The Court has recognized, also, that Robinson-Patman 'was enacted in 1936 to curb and prohibit all devices by which large buyers gained discriminatory preferences over smaller ones by virtue of their greater purchasing power.' (citations omitted). Because the Act is remedial, it is to be construed broadly to effectuate its purposes. (citations omitted).

460 U.S. at 159. The Court then held that the sale of pharmaceutical products to state and local government hospitals for resale in competition with private pharmacies is not exempt from the proscriptions of the Robinson-Patman Act. The view that Robinson-Patman Act constraints should apply to HMO purchases for resale in marketplace competition with retail pharmacies is further buttressed by this Court's decision in *Abbott Laboratories v Portland Retail Druggists Ass'n.*, 425 U.S. 1 (1976). There, interpreting the Nonprofit Institutions Act the Court construed the limited exemption provided for purchases made by designated nonprofit institutions "for their own use." 425 U.S. at 14. This court held that not all purchases

were thereby exempted from the Robinson-Patman Act, recognizing that were a nonprofit hospital allowed to purchase and sell drugs to all individuals (particularly "walk-in" patients) at a price less than that available to commercial pharmacies, the hospitals would be "devastatingly positioned with respect to competing pharmacies." 425 U.S. at 18.

The same rationale is applicable in the instant case. If the thinking of the Ninth Circuit is allowed to stand by this Court and Health Maintenance Organizations are permitted to buy drugs at lower prices than other pharmacies, and sell those drugs without restriction, there would result a severe distortion and disruption of the marketplace, a condition which the antitrust laws were intended to prevent. Such a result would reinstitute the chaotic marketplace situation thought by many to have been cured by this Court's decision in *Abbott Laboratories v. Portland Retail Druggists Ass'n., supra.* Now, Health Maintenance Organizations may be arrayed against and "devastatingly positioned," with respect to both government and non-government hospitals and community pharmacies. If the Ninth Circuit's opinion is allowed to stand, all other pharmaceutical service providers will remain subject to the Robinson-Patman Act, while $3 billion a year "nonprofit" HMOs will be exempt. Surely, in 1938, the architects of the Nonprofit Institutions Act did not contemplate and would not sanction such a result.

As noted above, the Ninth Circuit's conclusory pronouncement of what constitutes a "charitable institution" is superficial and is totally lacking in historical and economic analysis. The term "charitable" has been given formal recognition in the law for centuries, as the term emanates from the common law of charitable trusts. The general rule is that the word "charitable" at common law encompassed "trusts for the relief of poverty; trusts for the advancement of education, trusts for the advancement of religion; and trusts for other purposes beneficial to the community, not falling under any of the proceeding heads." B. HOPKINS, THE LAW OF TAX-EXEMPT ORGANIZATIONS (1983) at 45-48.

The term "charitable," under the English common law, was a most encompassing term, yet it remained a definable legal concept. The definition of the term "charitable" dates back to the definition of charitable purposes in the Preamble to the Statute of Charitable Uses of 1601. (Stat. 43 Eliz. I, c.4) The Statute itself is based upon holdings of the English Court of Chancery before 1601 and upon earlier experiences (such as the Codes of Justinian) of previous civilizations including those of Rome and Greece and early Judaism, as well as in many other early cultures and religions. The Statute enumerates certain "charitable" purposes, as follows:

> . . . some for relief of aged, impotent and poor people, some for maintenance of sick and maimed soldiers and mariners, schools of learning, free schools, and scholars in universities, some for repair of bridges, ports, havens, causeways, churches, sea-banks, and highways, some for education and preferment of orphans, some for or towards relief, stock or maintenance for houses of correction, some for marriages of poor maids, some for supportation, aid and help of young tradesmen, handicraftsmen and persons decayed, and others for relief or redemption of prisoners or captives, and for aid or ease of any poor inhabitants concerning payments of fifteens, setting out of soldiers and other taxes.

These and other classifications of the concept of charity were discussed by Lord Macnaghten in 1891, who said:

> Of all words in the English language bearing a popular as well as a legal significance I am not sure that there is one which more unmistakably has a technical meaning in the strictest sense of the term, that is a meaning clear and distinct, peculiar to the law as understood and administered in this country, and not depending upon or coterminous with the popular or vulgar use of the word.

Lord Macnaghten's discussion was cited with approval by this Court in *Evans* v. *Newton,* 382 U.S. 296, 308 (1966) (White, J., concurring). The term, "charitable," then, has a legal meaning

and is regarded as a term of art, while terms such as "philanthropy" remain popularized words lacking in legal significance.

The Ninth Circuit ignored the time honored common law definition of "charitable" and "charitable institution" which has developed over many years of English and American jurisprudence. As Professor Oleck in his well known treatise states:

> Charitable means liberal to those in need. It is equivalent to benevolent, beneficient, or eleemosynary. Eleemosynary itself means pertaining to the distribution of alms or bounty. Thus, an eleemosynary corporation is a corporation organized for the accomplishment of charitable or benevolent purposes.
>
> * * *
>
> A *charitable institution* is one devoted to performing a public service or one supported at least in part by public aid, or one that administers a charity.

H. OLECK, NON-PROFIT CORPORATIONS, ORGANIZATIONS AND ASSOCIATIONS (3rd Ed. 1976) at 578. The fundamental legal principle underlying every charitable organization is the care of the poor and needy.

The record reflects that the respondents are not "charitable" because they are not organized to care for the poor and in the absence of emergency do not give medical care to the indigent. They are in the business of selling medical care only to families who can afford to pay $2,000 per year (or receive coverage as a fringe benefit of employment). See App. at 2b.

The financial structure of the organization belies all claim to charitable status under the law. The realities of its financial structure as a "joint endeavor" with for-profit entities demonstrate clearly that the organization is not eleemysonary. In 1983 Kaiser generated 2.7 billion dollars in "Medical Expenses" which were paid to for-profit corporations. App. at 2a. The balance of 73 million dollars in expenses were paid to the administration of the health plan. *Id.* This financial arrangement constitutes a combination which clearly produces substan-

tial profits for the Medical Group partnerships and the Permante Service Corporation which are emphatically not "charitable institutions" entitled to exemption.

On a functional level, HMOs are competing head to head with other health plans and traditional health care providers for the consumer health dollar. The fact that an HMO is "nonprofit" does not render it exempt from the antitrust laws.

Respondents are not only large and powerful (whether they be nonprofit or for-profit) but they compete in the American economy precisely like any other business. This is graphically demonstrated by the following excerpt from a recent publication of the U.S. Department of Health and Human Services entitled *Guide to Development of Health Maintenance Organizations* (1982).

Subtask 3.1: Analyze Market Shares

Exhibit IV-16

Market Share Analysis

Carrier	X	Y	Z	HMO X	HMO Y	Others	Total
Market Share...	40%	25%	10%	5%	3%	17%	100%

When analyzing the resulting picture of the market, the HMO planner should pay particular attention to whether the market is concentrated or fragmented. In general, if one or two carriers dominate, then the market will be difficult to penetrate. The HMO should consider possible competitive reactions by a dominant carrier—reducing or holding premiums constant, massive advertising campaigns—and estimate its own ability to counteract such moves. A fragmented marketplace (unless there are several HMOs) will be easier to penetrate and existing competitors will have less leverage in developing counter-strategies.

Id., at IV 32

HMOs with the financial power to monopolize the pharmaceutical service market who exhibit the aggressive marketplace intent and behavior of the respondents are and ought to be subject to the Robinson-Patman Act.

CONCLUSION

APhA is dedicated to the preservation of adequate pharmaceutical service to meet public needs. This objective will fail if one segment of competing pharmaceutical service providers is economically disadvantaged so that it is eliminated or threatened with elimination. There is no interest sufficient to sanction the operation of health maintenance organizations and their pharmacies outside of the coverage of the antitrust laws when the result would be a disruption of a free marketplace. Your amicus respectfully urges this Court to grant the petition for writ of certiorari and reverse the decision of the Ninth Circuit below.

Respectfully submitted,

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APPENDIX A

KAISER FOUNDATION HEALTH PLAN, INC.
AND SUBSIDIARIES
AND KAISER FOUNDATION HOSPITALS

Financial Statements

Years Ended December 31, 1983 and 1982

KAISER FOUNDATION HEALTH PLAN, INC. AND SUBSIDIARIES AND KAISER FOUNDATION HOSPITALS

COMBINED STATEMENTS OF NET INCOME AND CHANGES IN FINANCIAL POSITION

Amounts in Thousands

	Years Ended December 31			
	1983		1982	
REVENUES:				
Members' dues	**$2,356,612**	**80.0%**	$1,956,526	80.0%
Supplemental charges to members	**110,430**	**3.7**	94,313	3.9
Medicare, Health Plan members	**385,119**	**13.1**	305,990	12.5
Nonplan and industrial	**70,190**	**2.4**	69,322	2.8
Other	**22,937**	**.8**	18,477	.8
TOTAL REVENUES	**2,945,288**	**100.0**	2,444,628	100.0
EXPENSES:				
Medical services	**1,439,007**	**48.8**	1,188,850	48.6
Hospital services	**992,233**	**33.7**	842,942	34.5
Outpatient pharmacy and optical services	**171,532**	**5.8**	139,465	5.7
Other benefit costs	**137,463**	**4.7**	106,496	4.4
Community service programs, less $5,088 and $5,905 from research grants and contracts	**26,893**	**.9**	22,865	.9
TOTAL MEDICAL AND HOSPITAL SERVICES	**2,767,128**	**93.9**	2,300,618	94.1
Health Plan administration	**73,557**	**2.5**	70,168	2.9
TOTAL EXPENSES	**2,840,685**	**96.4**	2,370,786	97.0
NET INCOME—RETAINED FOR CAPITAL REQUIREMENTS	**104,603**	**3.6%**	73,842	3.0%
Add back noncash charges to operations for depreciation of buildings and equipment	**96,073**		81,994	
FUNDS GENERATED FROM OPERATIONS	**200,676**		155,836	

	Years Ended December 31	
	1983	1982
OTHER SOURCES OF FUNDS:		
Decrease in working capital (Note H)	**10,997**	97,124
Proceeds from long-term borrowings	**142,578**	13,922
Increase (Decrease) in:		
Liability for physicians' retirement plan benefits	**24,856**	26,164
Noncurrent revenue deferred to reduce dues rates	**21,718**	(1,592)
Noncurrent liability for self-insured losses	**15,579**	4,944
TOTAL SOURCES OF FUNDS	**$ 416,404**	$ 296,398
APPLICATIONS OF FUNDS:		
Additions to land, buildings and equipment	**$ 282,056**	$ 252,385
Investments designated for facilities expenditures (Note D)	**76,869**	—
Additions to cash and securities segregated for physicians' retirement plan obligation	**24,856**	26,164
Principal payments on long-term debt	**7,799**	15,253
Acquisition of North Central Connecticut Health Maintenance Organization, Inc. and Kaiser/Prudential Health Plan, Inc. (Note B)	—	5,738
Other	**24,824**	(3,142)
TOTAL APPLICATIONS OF FUNDS	**$ 416,404**	$ 296,398

See notes to consolidated financial statements

COMBINED BALANCE SHEETS

Amounts in Thousands

	December 31	
	1983	1982
ASSETS		
CURRENT ASSETS:		
Cash, including interest-bearing deposits and short-term investments	**$ 128,095**	$ 27,047
Accounts receivable:		
Members' dues	**70,348**	63,697
Medicare	**39,606**	25,781
Patients, less allowance for uncollectible accounts of $14,209 and $9,981	**44,404**	40,501
Other	**7,278**	10,886
	161,636	140,865
Inventories	**33,493**	31,625
Prepaid expenses	**12,013**	7,126
TOTAL CURRENT ASSETS	**335,237**	206,663
CASH AND SECURITIES SEGREGATED FOR PHYSICIANS' RETIREMENT PLAN OBLIGATION (Note C)	**295,335**	270,479
INVESTMENTS DESIGNATED FOR FACILITIES EXPENDITURES (Note D)	**76,869**	—
LAND, BUILDINGS AND EQUIPMENT (Note D):		
Land	**131,358**	112,525
Buildings and improvements	**1,085,908**	931,371
Equipment	**330,896**	273,995
Construction in progress	**249,867**	205,698
	1,798,029	1,523,589
Less accumulated depreciation	**593,698**	503,944
	1,204,331	1,019,645
OTHER ASSETS	**24,515**	10,110
	$1,936,287	$1,506,897

	December 31	
	1983	1982
LIABILITIES AND NET WORTH		
CURRENT LIABILITIES:		
Accounts payable and accrued expenses	$ 180,515	$ 127,505
Due to associated medical groups	63,514	46,697
Payroll and related charges	97,316	81,764
Liability for self-insured losses (Note A)	47,187	37,060
Due collected in advance	49,013	43,983
Revenue deferred to reduce dues rates (Note A)	18,160	6,132
Other liabilities	46,000	31,570
Current installments on long-term debt	26,197	13,620
TOTAL CURRENT LIABILITIES	527,902	388,331
LIABILITY FOR PHYSICIANS' RETIREMENT PLAN BENEFITS (Note C)	295,335	270,479
LIABILITY FOR SELF-INSURED LOSSES, less current portion (Note A)	107,190	91,611
REVENUE DEFERRED TO REDUCE DUES RATES, less current portion (Note A)	29,568	7,850
LONG-TERM DEBT, less current installments (Note D)	365,222	243,020
CONTINGENCY (Note G)		
NET WORTH (Note F)	611,070	505,606
	$1,936,287	$1,506,897

See notes to combined financial statements

KAISER FOUNDATION HEALTH PLAN, INC. AND SUBSIDIARIES AND KAISER FOUNDATION HOSPITALS

NOTES TO COMBINED FINANCIAL STATEMENTS

Years Ended December 31, 1983 and 1982

NOTE A—Summary of Accounting Policies

General

The accompanying combined financial statements include Kaiser Foundation Health Plan, Inc. and subsidiaries—Kaiser Foundation Health Plan of Oregon, Kaiser Foundation Health Plan of Ohio, Kaiser Foundation Health Plan of Colorado, Kaiser-Georgetown Community Health Plan, Inc., Kaiser Foundation Health Plan of Texas, Kaiser Foundation Health Plan of Connecticut, Inc. (Health Plans) and Kaiser Foundation Hospitals (Hospitals).

Health Plans are nonprofit corporations whose capital is available for health care purposes. Hospitals is a nonprofit and charitable corporation whose capital is available only for charitable, educational, research and other hospital purposes, including construction of facilities and retirement of debt. With minor exceptions, income is exempt from federal and state income taxes. Intercompany balances and transactions have been eliminated.

Eight independent Medical Groups cooperate with Health Plans and Hospitals in the conduct of the Kaiser-Permanente Medical Care Program; however, their operations are not included in the combined financial statements. Health Plans contract with Hospitals and the Medical Groups to provide hospital and medical services to their members. Contract payments to the Medical Groups represent a substantial portion of the expenses of medical services reported in the statements of net income.

Revenue Recognition

Members' dues are recorded as revenue in the month for which members are entitled to service. Dues collected in advance are deferred.

Medicare revenue is subject to audit and possible retroactive adjustment. Provision has been made for estimated retroactive adjustments to the extent the probable outcome of such audits can be determined.

Approximately 8.7% and 8.3% of total revenue was derived under contracts with the United States Office of Personnel Management in 1983 and 1982, respectively.

Inventories

Inventories are valued at approximately the lower of cost (first-in, first-out method) or market.

Physicians' Retirement Plan

Securities segregated for physicians' retirement plan obligation are carried at cost. Interest earned and gain or loss on sale of the securities are added directly to, or deducted from, the recorded liability for physicians' retirement plan benefits. The remainder of the plan cost is charged to operations and added to the recorded liability.

Land, Buildings and Equipment

Land, buildings and equipment are stated at cost. Buildings and equipment are depreciated over estimated useful lives principally using accelerated methods. Depreciation included in expenses in 1983 and 1982 was $96,073,000 and $81,994,000, respectively. Pro forma depreciation expense and related accumulated depreciation amounts on a straight-line basis would be as follows:

	1983	1982
Straight-line depreciation	**$ 74,786,000**	$ 64,031,000
Accumulated depreciation at end of year	**$424,312,000**	$355,845,000

Expenditures for maintenance and repairs are charged to operations; expenditures for betterments and renewals which extend lives are capitalized. Gains or losses on retirements and disposals are included in operating results.

Other Assets

Included in other assets are start-up costs which are deferred and amortized over periods of three to five years, bond reserve funds, and debt issue expenses.

Pension Plans

The accrued costs of employee pension plans are funded currently. Accrued costs include the amortization of unfunded prior service costs over periods not exceeding 40 years.

Self-Insured Losses

Annual costs associated with self-insured losses (primarily for professional liability) are charged to operations based upon claims that have arisen during the year and reasonable estimates, based upon the experience of prior years, of losses incurred for which claims had not been filed prior to the end of the year. Such costs will be paid out over a period of years. The portion of such costs estimated to be payable during the next year is included in current liabilities.

Revenue Deferred to Reduce Dues Rates

Health Plans and one or more of the Medical Groups may agree that amounts of unanticipated revenue or cost savings would have been reflected as a reduction of members' dues rates for the current year had such additional revenue or cost savings been known or foreseeable at the time of establishing such rates. Agreements with the Medical Groups provide that these amounts will be carried forward to reduce dues rates in subsequent years. Because of these contractual understandings, Health Plans do not recognize these amounts in determining revenues of the current year. The portion to be applied during the next year is included in current liabilities.

Prior Year Financial Statements

Certain amounts for the prior year have been reclassified to conform to the 1983 presentation.

NOTE B—Acquisitions

Kaiser Foundation Health Plan, Inc. assumed control of North Central Connecticut Health Maintenance Organization, Inc. on July 1, 1982 and Kaiser/Prudential Health Plan, Inc. on April 20, 1982. The names of the plans were changed to Kaiser Foundation Health Plan of Connecticut, Inc. and Kaiser Foundation Health Plan of Texas, respectively. Liabilities exceeded assets acquired by $2,863,000 and $2,875,000, respectively, and these amounts have been treated as reductions of retained income in the combined balance sheets. The statements of net income include the operating results of these plans since their dates of acquisition.

NOTE C—Physicians' Retirement Plan

Certain of the Health Plans have a retirement plan that covers some physicians serving Health Plan members. The plan provides for defined retirement and disability benefits determined by length of service and level of compensation of each participating physician. Prior service costs are amortized over a period of 30 years. The plan is not subject to the Employee Retirement Income Security Act of 1974.

The following is a summary of changes in the liability for physicians' retirement plan benefits:

	1983	1982
Balance at January 1	**$270,479,000**	$244,315,000
Provision for the year	**5,231,000**	3,853,000
Net income from segregated assets	**23,737,000**	25,145,000
Benefits paid	**(4,112,000)**	(2,834,000)
Balance at December 31	**$295,335,000**	$270,479,000

The recorded liability is approximately equal to the actuarial present value of accumulated plan benefits. Cash and marketable fixed income securities with a cost equal to the liability have been segregated. These assets are general assets of Kaiser Foundation Health Plan, Inc. and the claims of participants in the retirement plan have no preferred status or other priority over claims of other general creditors. The quoted market value of the securities held at December 31, 1983 was approximately $11 million less than cost. As of December 31, 1983 the yield to maturity on these securities, based on cost, was 10.5%. Certain Medical Groups have adopted their own qualified retirement plans.

NOTE D— Long-Term Debt, Bank Lines of Credit and Construction of Facilities

	December 31	
	1983	1982
Mortgage notes:		
6% to 10% due 1984 to 2000..	**$171,425,000**	$172,000,000
Unsecured debt:		
Note due 1987—13.5%.....	**40,000,000**	40,000,000
California Health Facilities Authority:		
Serial and Term Bonds due 1984 to 2013—5% to 9.125%.....	**75,000,000**	—
Semiannual Tender Bonds due 2013—5.6% adjustable beginning April 1, 1984	**60,000,000**	—
Other.....	**44,994,000**	44,640,000
	391,419,000	256,640,000
Less current installments on long-term debt.....	**26,197,000**	13,620,000
	$365,222,000	$243,020,000

During 1983 the California Health Facilities Authority issued bonds for the benefit of Hospitals in the amount of $135,000,000 to be used for facilities expenditures. At December 31, 1983 unexpended proceeds from these bonds were $76,869,000. Bonds reserve funds required by the agreements amounting of $10,852,000 are included in other assets.

Required principal payments on long-term debt are $26,197,000 in 1984, $28,895,000 in 1985, $33,652,000 in 1986, $39,719,000 in 1987, $18,744,000 in 1988 and varying annual payments through 2013. Maturities are based on contractual agreements. Repurchase of tender bonds may be required at earlier dates at the holder's option. Substantially all land, buildings and equipment are pledged as collateral for mortgage notes and other notes payable. Interest cost incurred during 1983 was $32,710,000 of which $14,039,000 was capitalized. Interest cost incurred during 1982 was $26,650,000 of which $11,337,000 was capitalized. The organizations are in compliance with restrictive covenants in financing agreements.

Hospitals has bank lines of credit totaling $25 million which expire in 1984. No amounts were outstanding at December 31, 1983.

Facility expenditures not yet incurred for projects undertaken through 1983 and those approved for commencement during 1984 aggregated approximately $645 million at December 31, 1983. These projects are scheduled for substantial completion by the end of 1987.

NOTE E—Pension Plans

Health Plans and Hospitals have several pension plans covering substantially all of their employees. Annual contributions to the plans equal the amounts accrued for pension

expense. A comparison of accumulated plan benefits and plan net assets of defined benefit plans at the most recent valuation date is:

	January 1	
	1983	1982
Actuarial present value of accumulated plan benefits:		
Vested	**$ 80,044,000**	$64,083,000
Nonvested	**17,733,000**	14,876,000
	$ 97,777,000	$78,959,000
Net assets, at market, available for benefits	**$116,224,000**	$78,175,000

The assumed rate of return used in determining the actuarial present value of accumulated plan benefits was 7.0% for both 1983 and 1982.

The total pension expense for 1983 and 1982 was $36,681,000 and $32,170,000, respectively, including contributions to multiemployer plans.

NOTE F—Net Worth

The following is a summary of changes in net worth:

	1983	1982
Donated:		
Balance at January 1	**$ 28,758**	$ 25,239
Donations received	**1,026**	6,140
Less donations made	**165**	2,621
Balance at December 31	**29,619**	28,758
Retained income:		
Balance at January 1	**476,848**	408,744
Net income	**104,603**	73,842
Deduct—acquisitions (Note B)	**—**	5,738
Balance at December 31	**581,451**	476,848
Total Net Worth	**$611,070**	$505,606

NOTE G—Contingency

Actions alleging violation of federal antitrust laws have been commenced against Health Plans and Hospitals in federal courts in California on behalf of a purported class consisting of present and former owners of retail or community pharmacies in California, Oregon and Washington in areas served by the Kaiser-Permanente Medical Care Program, which actions pray for unspecified but potentially substantial treble damages. Health Plans and Hospitals made pretrial motions to dismiss the actions, which motions were granted by the District Court. The dismissal was reversed on appeal and the actions were returned to the District Court. Health Plans and Hospitals again made pretrial motions to dismiss the actions which were granted by the District Court on February 14, 1983. The plaintiffs have appealed. In the opinion of counsel, it seems probable that disposition of these actions will be within limits which, in the judgment of management, would not have a material effect on the combined financial position of Health Plans and Hospitals.

NOTE H—Increase (Decrease) in Working Capital Components

	December 31	
	1983	1982
Cash	**$101,048,000**	$(69,695,000)
Accounts receivable	**20,771,000**	31,629,000
Inventories	**1,868,000**	6,391,000
Prepaid expenses	**4,887,000**	1,957,000
Accounts payable and accrued expenses	**(53,010,000)**	(28,271,000)
Due to associated medical groups	**(16,817,000)**	(2,076,000)
Payroll and related charges	**(15,552,000)**	(18,559,000)
Liability for self-insured losses	**(10,127,000)**	(2,736,000)
Dues collected in advance	**(5,030,000)**	(6,805,000)
Revenue deferred to reduce dues rates	**(12,028,000)**	(4,230,000)
Other liabilities	**(14,430,000)**	(3,813,000)
Current installments on long-term debt	**(12,577,000)**	(916,000)
Decrease in Working Capital	**$(10,997,000)**	$(97,124,000)

TOUCHE ROSS & CO.
ONE MARITIME PLAZA
SAN FRANCISCO, CALIFORNIA

February 22, 1984

Boards of Directors
Kaiser Foundation Health Plan, Inc.
and Subsidiaries and
Kaiser Foundation Hospitals
Oakland, California

We have examined the combined balance sheets of Kaiser Foundation Health Plan, Inc. and Subsidiaries and Kaiser Foundation Hospitals as of December 31, 1983 and 1982, and the related combined statements of net income and changes in financial position for the years then ended. Our examinations were made in accordance with generally accepted auditing standards and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the combined financial statements referred to above present fairly the financial position of Kaiser Foundation Health Plan, Inc. and Subsidiaries and Kaiser Foundation Hospitals as of December 31, 1983 and 1982, and the results of their operations and the changes in their financial position for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Touche Ross & Co.

Certified Public Accountants

APPENDIX B

The New York Times, Monday, December 17, 1984

SURGE OF PREPAID HEALTH PLANS

H.M.O. Cost Savings Cited

By Milt Freudenheim

Until recently, the prepaid medical plans known as H.M.O.'s were dismissed as relatively expensive aberrations that flourished mainly in California and among government employees. But they have expanded greatly of late, as major employers have become much more conscious of worker health costs.

The reason: Skyrocketing medical costs have now made H.M.O., or health maintenance organization, plans highly competitive—and often cheaper—than traditional medical insurance.

Riding the crest of what one medical economist calls "the early stages of an industrial revolution in health care," the H.M.O.'s have added 1.2 million members this year, bringing their estimated total enrollment to 15 million.

And the H.M.O.'s expect a further increase when new Medicare regulations take effect. Under the new rules, Medicare will pay H.M.O.'s directly for memberships for the elderly and disabled, a potential total of 30 million people. The Secretary of Health and Human Services, Margaret M. Heckler, sent the new regulations to the Office of Management and Budget this week for final review.

THE LARGEST H.M.O.'s

Ranked by enrollment on Dec. 31, 1983

Kaiser Health Plans	**4,416,480**
Cigna Healthplan Inc.	**663,096**
Prucare	**338,346**
HealthAmerica Corp.	**332,898**
Mexicare Health Plans, Inc.	**296,807**
U.S. Health Care Systems	**239,805**
Charter Med Inc.	**235,063**
Family Health Program	**147,677**
Share Development Corp.	**82,146**
Hancock/Dikewood Inc.	**72,846**

Source: Interstudy

Some H.M.O. executives are leery of getting deeply involved in business with the Government, but a spokesman for the prepaid plans, James F. Doherty, executive director of Group Health Association of America, welcomed the new regulations as "the major development since the enactment of Medicare."

H.M.O. members pay a set fee (the national average is $54 a month for individuals, $172 for families) and are typically assured of 100 percent coverage of most hospital and medical bills, plus extras such as free physical examinations.

Traditional medical coverages, such as Blue Cross and Blue Shield, are insurance plans: Subscribers, or their private physicians or hospitals, are reimbursed after treatment. Often the reimbursement does not fully cover the fees involved.

A 10-year study by the Rand Corporation reported in June that health costs of H.M.O. members were 25 percent lower than for people covered by the usual fee-for-service plans—largely, Rand said, because H.M.O. members were admitted to hospitals 40 percent less frequently.

Critics in the medical profession contend that by using hospitals less, H.M.O.'s stint on quality. But recent studies,

notably one at the prestigious Mayo Clinic in Minnesota, have shown wide geographical variations in hospital use. Many physicians have been joining, or forming, group practices and competing for employer health contracts by minimizing costs and using hospitals less.

To fight back, some traditional insurers have started their own H.M.O.'s. Blue Cross and Blue Shield associations have started 57 H.M.O.'s in 28 states, which have recruited 1.8 million members. Among the major insurers, Cigna Healthplan Inc., the largest investor-owned H.M.O., currently has 718,000 members in the West and South. Prudential Health Care Plan Inc. has 400,000 members for its Prucare system in 13 cities.

In a race to establish national networks, Kaiser Foundation Health Plan, Inc., the largest H.M.O., is spending $300 million on expansion this year, according to Robert J. Erickson, senior vice president. He said Kaiser plans to spend $2 billion in the next five years. From its California base, Kaiser has jumped to nine other states and the District of Columbia. It added 200,000 members this year, for a total of 4.6 million. Revenues passed $3 billion.

In 1985, Kaiser will add three more states, including New York, where it plans to expand the Westchester Community Health Plan, a small H.M.O. in White Plains.

Tax-Exempt Financing

Beginning in the early 1980's, Kaiser in California and other H.M.O.'s in Seattle and Cambridge, Mass., were able to obtain tax-exempt financing through state agencies, said Peter A. Wadsworth, vice president at Kidder, Peabody & Company's health finance group.

"From the investor point of view, H.M.O.'s have proven that they can grow fast and profitably," he said. "They get their money before they spend it, and the major companies each have revenues in excess of $100 million."

Mr. Wadsworth said that the restrictions on tax-exempt financing that go into effect Jan. 1 are not expected to adversely affect H.M.O.'s. However, the new tax revision proposals recently announced by the Treasury Department—which would curb tax-exempt financings for private use—could affect H.M.O.'s, although some experts believe that exceptions may be made for hospitals.

Mr. Wadsworth has tracked five investor-owned H.M.O.'s that have gone public since early 1963. According to Mr. Wadsworth and Kidder, Peabody, the five have done well by investors, although their stock prices have pulled back from late October, when they reached a peak.

The five stocks are: United States Health Care Systems, which has gone from an initial offering price (adjusted for a stock split) of $5.93 to $28, yesterday's close; HealthAmerica which has gone from $6.40 (adjusted for a stock split) to $14.75; Maxicare Health Plans, from $16 to $20; Independence Health Plan, from $13 to $18, and Peak Health Care, $10 to $11.75. All trade over the counter.

Private or foundation-owned H.M.O.'s cannot depend on stock offerings. The Health Insurance Plan of Greater New York Inc. raised $3.5 million in July with a tax-exempt offering through the New Jersey Health Facilities Financing Authority. Robert L. Biblo, H.I.P.'s president, said the money would go toward a new "multi-specialty ambulatory center" in Paramus, N.J.

New York Legislation

Such tax-exempt financing is not now available to H.M.O.'s in New York State, Mr. Biblo said. But the Legislature just passed a bill that will allow such financings. The bill awaits Governor Cuomo's signature.

"Our Long Island facilities are at capacity," he said. "Part of our problem is to get access to capital, similar to what nonprofit hospitals have now." While waiting, H.I.P. arranged a $35 million loan in October.

H.I.P., with 900,000 members, is the nation's second-largest H.M.O. It was started by Mayor Fiorello La Guardia, primarily for city employees, in 1944, long before the health maintenace organization label was invented during the Nixon Administration. H.I.P. has had "a surge of growth in the past four years," Mr. Biblo said, as private companies have begun offering H.I.P. to employees. "We now have a base of 3,000 accounts," he said.

'A Cottage Industry'

"Medical care is still an organized cottage industry," says Phillip N. Bredesen, chairman and chief executive officer of HealthAmerica in Nashville. HealthAmerica has moved into 26 metropolitan areas, mainly in medium-sized cities, Mr. Bredesen said. New Orleans, the last big city without an H.M.O., will lose that distinction next month, when Health-America and a competing chain, Maxicare Health Plans Inc., begin operations there.

"As the industry heats up and becomes more competitive, it is likely to be less so in those kinds of markets," Mr. Bredesen said. "All the big players are in Chicago."

'All Having Fun'

"They are all having fun here," said Frank Nicholson, secretary-treasurer of the Chicago-based Illnois Association of H.M.O.'s. Enrollment in Chicago rose by 49 percent in the year ending in July, he said.

Chicago, the home base of such pillars of the establishment as the American Medical Association and the American Hospital Association, had long been tough terrain for H.M.O.'s. Now this has changed. "More and more physicians and hospitals are knocking on the H.M.O. doors," said Mr. Nicholson, who is also vice president of Blue Cross and Blue Shield's HMO Illinois, the state's largest prepaid plan. "Most marketable hospitals and medical staffs have affiliated with one."

But until a few years ago, H.M.O.'s were "virtually outlawed in 38 states," recalled Mr. Doherty of the national trade association. "Some states used to require H.M.O.'s to maintain reserves similar to insurance companies. The A.M.A. had a rule against contract practice of medicine. H.M.O.'s boards were often required to have physician majorities."

Restrictions were pushed aside by Federal laws and the Supreme Court's 1975 Goldfarb decision that held the learned professions subject to antitrust law, said Alain C. Entheven, a professor of management in the Stanford University Graduate School of Business. He attributes the rapid growth of H.M.O.'s, in part, to "a large decline in the political and economic power of the medical profession" caused by the 65 percent increase in new doctors since 1960.